The Lewin Group
Questions & Answers re: Baseline Analysis of Colorado Health Care Spending
June 12th and June 19th, 2007

Q1: Where is Cover Colorado listed in Figure 1 (spending by source of funding)?
A: Non-group coverage.

Q2: Do the figures that refer to "Medicaid" coverage also include CHP+?
A: Yes.

Q3: Where is CHAMPVA (dependents of disabled veterans counted) in Figure 1?
A: It is recorded with TRICARE/CHAMPUS.

Q4: Why does CO have a higher medical inflation rate than the national average?
A: Not sure. This would require considerable study to answer. It could be due to consolidation of hospitals and the number of for-profit hospitals.

Q5: For Figure 3, you note that the migration adjustment is based on Medicare data. Is there an age-adjustment?
A: No we do not age-adjust. Medicare is the only available data source. Because Medicare migration is likely to overstate migration for the remainder of the population, we will apply the migration adjustment to Medicare only in the final, June 29th report.

Q6: You use a lot of data from the CMS Office of the Actuary. Is this Medicare and Medicaid data only?
A: In addition to administering the Medicare and Medicaid programs, CMS sponsors an ongoing process for collecting data on total health spending throughout the system, including both public and private spending on a state-by-state basis. For example, they use the AHA data on hospitals, business (employer) survey data and physician surveys.

Q7: Can you specify the original data sources in all of your figures and charts?
A: Yes. Sources are now being expanded upon in the final, June 29th report.

Q8: If you have a capitated payer how is that captured?
A: We allocate Capitated Payments to health plans across health services categories in proportion to the distribution of spending by service category under fee-for-service plans.

Q9: Could you identify what is captured in Figure 1 under "other personal" care and "other professionals"? Can you include these clarifications in the text or a footnote in the report?
A: "Other professional" services are those provided by health practitioners other than physicians or dentists, such as private-duty nurses, chiropractors, podiatrists, optometrists psychologists, podiatrists, therapists and mid-wives. "Other Personal" services include industrial inplant services (i.e. health care provided by employers for employees at the employer's establishment), and government expenditures for medical care not delivered in traditional medical provider sites (e.g. community centers, senior citizens centers, schools, and military field stations). Home and Community Waiver programs comprise a

large portion of "Other Personal" spending. Other personal care also includes physical, occupational and speech therapy.

Q10: If "other personal" care includes Medicaid transportation and HCBS waivers services, it will make Medicaid reforms difficult to identify. This format suggests that actuaries are using a private sector orientation to put together costs for modeling. How will Medicaid reforms be modeled?
A: The populations targeted for coverage under the four policy options include non-aged and non-disabled uninsured populations that would use few HCBS services. We are basing costs for Medicaid expansion proposals on the utilization profiles of parents and children in the existing program, which our actuaries are revising to reflect unique features of the benefits packages proposed by the authors. We will describe the data and methods used in our report for each policy option.

Q11: To what extent are the Medicaid growth rates adjusted to reflect Medicaid cuts and slow economic growth in Colorado between 2000 & 2004? Is it appropriate to use the growth rate during this period and apply it as a trend factor?
A: We rely upon the projections of Medicaid enrollment and spending used in the budgetary process. No additional trend analysis is required to develop our projections for FY 2007 – 2008. (HCPF and JBC staff agreed with the trend factor at the June 12, 2007 meeting.)

Q12: Where did we identify the membership growth from baseline?
A: The CPS data is the source of population estimate. We model population growth and demographic changes using population projections developed by the Bureau of the Census based upon state-specific trend factors. These reflect population trends by age, gender and race / ethnicity.

Q13: Are the state department of corrections in these figures?
A: Our health spending estimates include health spending for the department of corrections. In our next draft of the health spending paper, we will show this spending as a separate line-item. These people are excluded from our policy options analyses, which focus on the civilian, non-institutionalized population.

Q14*: Is Indian Health Services accounted for in the spending estimates?*
A: We are trying to obtain these data for Colorado. IHS spending is included in the final, June 29th health spending report as a separate line-item.

Q15: Where are the ERISA numbers being counted, for example in Figure 1? Can you report ERISA separately? Won't you need to identify those enrolled ERISA plans to model certain proposals?
A: Our private insurance spending estimates include those in both self-funded (i.e., ERISA plans) and fully-insured plans. AHRQ estimates that about three-fifths of workers with employer health benefits in Colorado are in self-funded plans.

Q16: Does MEPS and CPS count "people" in a consistent way?

A: Yes. They are both household based surveys that include the Civilian non-institutionalized population.

Q17: Will the final reports include standard errors (or confidence intervals) around key estimates?

A: I believe the question about standard errors was motivated by the chart on MEPS premium estimates. In the table below we display the standard errors associated with the Premium estimates from the employer survey conducted by the Agency for HealthCare Research and Quality (AHRQ). This is from the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC).

2004 MEPS Average Premiums and Standard Errors

	All employees	Under 10 employees	10-24 employees	25-99 employees	100-999 employees	1,000 or more employees
Single Coverage						
Premium Estimates	3,684	4,118	3,664	3,837	3,772	3,537
Standard Error	106.52	286.92	152.43	225.25	164.6	156.35
Family Coverage						
Premium Estimates	10,228	10,586	9,238	9,399	11,210	10,085
Standard Error	308.19	615.64	575.75	1,746.03	245.68	483.11

The data and methods required to provide confidence intervals for micro-simulation model estimates do not exist at this time.

Q18: Is it possible to unbundle inpatient and outpatient $?

A: We estimate that hospital spending in FY 2007- 2008 will be $10.5 billion, including $6.5 billion in inpatient care and $3.9 billion in out-patient care

Q19: Where are ambulatory surgery centers counted in Figure 1 of the report (as hospital?)

A: Spending in free-standing ambulatory surgical centers is recorded as physician income. For hospital based ambulatory care centers, the facilities charge is recorded as hospital income with the physician fee for no-hospital staff recorded as physician income.

Q20: How does Colorado compare with neighboring states with regard to annual growth rates and migration patterns?

A: Below are the growth rates and aggregate migration patterns for Colorado and adjacent States.

Average Annual Growth Rates of Rocky Mountain States and overall Migration Patterns

	Provider Spending Estimates			
	2000	2004	AAGR 2000-2004	Migration Pattern
Kansas	$10,402	$14,061	7.8%	4.7%
Nebraska	$7,015	$9,715	8.5%	-1.3%

Arizona	$15,891	$23,639	10.4%	-3.6%
New Mexico	$5,457	$7,644	8.8%	3.9%
Colorado	$15,711	$21,807	8.5%	-2.4%
Utah	$6,458	$9,543	10.3%	-3.4%
Wyoming	$1,615	$2,231	8.4%	16.3%

The spending data is from the State Health Accounts developed by the Centers for Medicare & Medicaid Services, as discussed in the paper. The Migration patterns are also based on CMS estimates of total resident spending versus total provider spending for 1998 (this is the more recent year of data available from CMS).

Q21: With regard to the hospital cost-shifting chart, are estimates of private insurance too high?
A: Yes. Our revised hospital cost-shift chart is included in the final, June 29th report of Colorado health spending. The source of the differences between the original and revised version of the Colorado cost shift charts are as follows. After consultation with the Colorado Hospital Association staff, we modified our analysis to more closely align our methodology with their approach. First, we removed bad debt from the calculation of the cost to charge ratio (RCC) and the all payer cost calculations. Second, we removed Self-pay from the private payer category and created a separate Self-pay category that included self-pay as well as charity care. This had the effect of significantly reducing the private payer charge to cost ratio.

Q22: Can you be sure to clearly label all charts: fix typos (e.g., clarify when "Medicaid" refers to Medicaid/CHP+, clarify when the Medicare data includes dual-eligibles).
A: We have made these changes.

Q23: Are the MEPS data estimates consistent with the findings of the MSEC?
A: The MEPS and the MSEC data produce similar estimates of employer health spending. This is discussed in the final, June 29th report.

Q24: What is included in "other public" on the pie chart with regard to uninsured spending?
A: For the uninsured, other public spending includes spending under publicly funded clinics, FQHCs, Rural Health clinics, public hospitals and other local government indigent care programs. See Figure 15 of the health spending paper.

Q25: In the Figure that addresses hospital cost-shifting, do the calculations specifically include Disproportionate Share payments? They aren't explicitly mentioned on page 39, but there is something called tax subsidies. If DSH payments aren't included then the picture, isn't the understanding we have of uncompensated care seriously skewed?

A: The estimates in our revised Figure do reflect the effect of DSH.

Q26: Page 1: Introduction. Lewin correctly highlights a major problem with the existing system: "…our current multi-payer system [is not] conducive to collecting and evaluating health expenditures." It is critical that a better system (eg CORHIO) be developed for future

management efficiency and effectiveness. "You cannot manage without timely, accurate data," WE Deming (Quality Improvement - 14 Principles),

A: No Comment. It is not our role to advocate particular policy measures.

Q27: Page 2-F1 (Detailed on pg 32-F31): Healthcare Spending in CO. Additional sources of funds that I don't see recognized would include payments from auto insurance and other medical liability programs. I note that the medical expense portion of malpractice would be recognized under the "professional liability" expense of providers.

A: The cost of care due to accidents and malpractice are included in our spending estimates. Much of these costs are initially covered by insurance or through out-of-pocket payments. Subsequent auto and malpractice insurance payments go to the individual as income that may or may not be used for health services. Separate estimates of these amounts are not available.

Q28: Administrative expenses of providers need to be recognized, and this issue is explored on pages 35-37.
A: These estimates are revised in the final June 29th, report.

Q29: Administrative expenses of employers to manage their healthcare benefit programs is not recognized (which is also tax-subsidized, so this is a publicly financed portion of the overall picture).
A: This is a good point. Unfortunately, the cost to employers of administering their health plans is not counted in the definition of health expenses used by CMS in developing their state and national health spending estimates. There are no data on these costs. We will address this issue under policy proposals that impact on these costs.

Q30: Page 18: Are expenses for native Americans recognized under "other Public Funds" or under "Dept of Public Health"?

A: See Q14.

Q31: Page 20-F17: Employer-Sponsored Insurance. The employer portion of healthcare premiums is subsidized as a tax-deductible expense, so this portion should be recognized as a 'public' expense rather than 'private'.

A: The tax expenditure for health benefits is a very complex issue that is separate from this study. It would take some time to develop these estimates for the group.

Q32: The portion of premiums paid by employees should be recognized in the summary (pg32-F31), as detailed on pg21-F18. This portion of premiums is related to out-of-pocket expense and that combined individual expense is also tax-subsidized on the individual tax return (eg greater than $7500).
A: We will address these questions if they are affected by one of the policy options.

Q33: There is no recognition for Federal retirees, the expense for FEHBP.
A: We included an estimate of federal retirees in the revised, June 29th report.

Q34: Page 28-F2. The medical loss ratio should be high-lighted! This is an important element of overall total administrative expenses, and could be further explained by Lewin. Admin expenses are expressed as 7% of total healthcare expense on pg2-F1 (and pg32-F31). But admin expenses show up for businesses, hospitals and physicians as well. The medical loss ratio for private insurers is 80%. The 20% overhead includes administration expense, plus sales and marketing, lobbying, and profits. In fact, over 30% of national healthcare expenditure is consumed by administrative expense of one kind or another (Woolhandler, et al "Costs of Health Administration in the U.S.and Canada," NEJM 349(8) Sept. 21, 2003). Lewin has recognized some of these expenses in other areas, but they need to be high-lighted as an opportunity cost of the current system. Also noted is the 66% loss ratio of individual private insurance, with overhead of 34%, the highest of all the private insurance categories.

A: Our policy is to estimate the figures and leave it to the audience to debate their implications.

Q35: Page 29-F30: Correctional Programs. It appears that the $226 million for healthcare expense in correctional institutions is mentioned, but I don't understand why it would not be included in "Other Public Funds"

A: As discussed above, we will separate it in the report. It is included for completeness. It is not affected by the policy options we are considering.

Q36: Page 37-F33: Professional Insurance Liability. I have been under the impression that the Medicare reimbursement schedules provided for a 5% malpractice reimbursement rate. Lewin only shows a 2.5% expense for physicians. And a high proportion of this expense is paid for direct or 'future projected' medical care. Of course, there is an administrative burden, and an opportunity cost (see below) for this component of health spending.

A: Our analysis is based upon the MGMA data which provides the most comprehensive data available on provider administration and other overhead costs.

Q37: Page 37-F34: Contractual discounts and Cost-Shifting. I appreciate the addition of this explanation and the use of their "Cost-Shift Graphic". The earlier note by Lewin that "…our current multi-payer system [is not] conducive to collecting and evaluating health expenditures," must be under-scored. One of the Commissioners (a physician) made the comment that he "really didn't know what a service or procedure" cost [in his practice]. This is because of the contractual adjustments required by Medicare and Medicaid, and granted to third-party payers who 'negotiate' with their 'preferred providers'. Not only does the shortfall of government payments need to be covered by private insurance, but the uninsured, those who usually are least able, end up being billed 'list price'. This is the reason for safety net providers. This is the reason many providers refuse to take Medicare or Medicaid patients.

A: We are still working with CHA to be sure our figures here make sense. This diagram has been a powerful tool in explaining hospital finance and the cost-shift.

Q38: OpportunityCosts:This analysis represents a formidable effort to capture the overall expenses of healthcare in Colorado. There is, however, an area deserving of it's own paragraph. These are the "costs of poor quality" and "alternative uses of funds", described by economists as "opportunity costs". These are the costs we incur by continuing with our current system. For

example, by removing the waste in admin expenses, the money freed up in business and individual enterprises could be used to purchase other things. In business, opportunity costs include lost productivity, replacement of staff who are not working, disability expense, etc. Many of these expenses are detailed in an article by Midwest Business Group on Health in collaboration with Juran Institute, Inc. and the Severn Group, inc., "Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership," Chicago, June 2002. In addition, there are opportunity costs associated with the 30% or more estimated cost of medical care, based on best practice guidelines, that is unnecessary, redundant or inappropriate, even harmful, as described by the Dartmouth Health Atlas and other studies. What is the cost of 100,000 deaths, conservatively estimated, resulting from errors in medical care? (Institute of Medicine, To Err Is Human: Building a Safer Health System, 1998.)What is the net cost of the fact that over 50% of medical care that should be provided, according to best practice guidelines, is NOT being provided? (Facts about Costs, Access and Quality (in US Healthcare) – RandOrganization, 2005). With regard to the medical expenses of correctional institutions, what is the cost of lost productivity and recidivism due to the failure of treatment programs for such inmates?

A: Our analysis focuses on the dollar amounts paid for health services and administration.

The Lewin Group
Questions & Answers re: The Uninsured in Colorado
June 12th and June 19th, 2007

Q1: Won't it be a problem to "correct" for the Medicaid undercount because you per capita spending estimates will be off?
A: Actually, this is why you need to correct the data.

Q2: What is the data source for the Figures on the uninsured by connection to workforce? Are these questions on CPS?
A: Yes, they are based upon the March CPS data. Data from the February CPS was used to estimate the number of uninsured workers who decline coverage.

Q3: Figures 11 and 12 refer to the over 500% FPL as a "policy relevant category", is this because it is a cut-off line for affordability?
A: The cut-off line for affordability is arbitrary. However, this is the income level at which Massachusetts, for example, applies and enforces an individual mandate.

Q4: What is the standard of cost applied to affordability?
A: There is no standard. It is a difficult issue. Some have used the federal tax thresholds (e.g., for deductibility of out-pocket payments).

Q5: How did Lewin get to average monthly estimates of uninsured?
A: CPS asks what coverage in prior calendar year? Modeling techniques are used to simulate coverage on a monthly basis. (A more detailed explanation is found in the HBSM documentation.)

Q6: You use different data sources (e.g., survey data, HCPF administrative data) that have different conventions for counting people. Medicaid, for instance, allows retroactivity. How do we ensure that when applying per cap costs to counts of people, that we are using consistent assumptions for counting people?
A: The model counts separately retroactive months and subsequent months of enrollment. This enables us to define newly enrolled months in a way which is most consistent with the historical program data we are using. We are still resolving these details.

Q7: How is the data capturing bouncing on and off the roles of Medicaid?
A: This is why we use average monthly estimates.

Q8: Does CO Medicaid still use the asset test and how is this captured?
A: Colorado has recently stopped requiring an asset test. The model does not use the assets test to simulate Medicaid eligibility.

Q9: Did you include any data on under-insured and what is your definition?
A: There is no standard definition. Common approaches include: large out-of-pocket expenses (e.g., above $5,000) or health spending that is a high proportion of income. Our

options analyses will show the impact of these proposals on out-of-pocket spending for people with high health expenses.

Q10: Can you provide analysis of high deductible plans?
A: Yes. Research shows that cost-sharing affects utilization. Data from the RAND study on health insurance, for example, shows utilization when a co-pay is imposed (RAND study from the 70's), there is reduced utilization. The study revealed some contradictory evidence on how quality and health status are impacted.